CARE OF ELDERLY PERSONS WHO REFUSE HEALTH SUPPORT SERVICES

PREPARED BY MARILOU MCPHEDRAN

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PREPARED BY

MARILOU MCPHEDRAN

HEALTH ADVOCATE, DEPARTMENT OF PUBLIC HEALTH

APRIL, 1982

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Local Board of Health April 26, 1982

SUMMARY

CARE OF ELDERLY PERSONS WHO REFUSE HEALTH SUPPORT SERVICES

Prepared at the request of the Local Board of Health, this Report is a response from the Medical Officer of Health to:

a) a letter from the Association of Women Electors of Metropolitan Toronto dated November 17, 1980 asking whether public health nurses had been informed of permitted actions under The Mental Health Act and The Mental Incompetancy Act, and whether the welfare of the elderly had been made a priority in the Departmental reorganization; and

b) the May 12, 1981 report from the Commissioner of Planning and Development resulting from the inquest into the death of Miss Lillian Hess, with recommendations that the Medical Officer of Health be requested to report on a means of implementing a 24-hour emergency reponse service, and that the Medical Officer of Health be requested to report on the advocacy role of the Department of Public Health concerning the needs of an aging population.

Policy development, program implementation, and reorganization are all being done in the context of principles adopted by the Local Board of Health and City Council in the policy document Public Health in the 1980's, part of which requires:

> "...reducing the Department's propensity to assume responsibility for all health-related problems which other agencies can't or won't handle.
>
> "...necessary service (treatment) programs to deal with urgent health problems - but in a gap-filling role only, and for a very limited program life."

This policy document encourages programs directed at the societal basis of problems, noting that:

> "...maintenance of that pattern [one-to-one treatment] tends to maintain the problems".

The Department's practice in the three and a half years since Public Health in the 1980's was adopted is still substantially different from the document's stated goals, but progress has to be made at a measured pace in order to ensure that humane solutions are in place before long-term individual care by Department staff can be discontinued.

Local Board of Health April 26, 1982

PART I

STATUTORY POWERS OF INTERVENTION IN PUBLIC HEALTH MATTERS AS RELATED TO THE ELDERLY

Some health care professionals favour changes in legislation such as:

a) broader and clearer terms under The Mental Health Act regarding involuntary committal;

b) easier access to the Public Trustee for the administration of an elderly person's property and interests;

c) new guardianship legislation for the administration of an elderly person's personal needs (housing, medical treatment, lifestyle)

Not everyone agrees with the above. It is emphasized that legislative reform is only a small part of the solution. There is concern that broader legislative authority would only lead to premature institutionalization and other inappropriate services because community-based services simply do not exist for most elderly people who need them.

A. EXISTING STATUTES

The Mental Health Act

Sections 9, 10 and 11 are key to the process of involuntary committal. Section 9 describes the circumstances under which Form 1 (application by physician for psychiatric assessment) may be signed by a physician as a first step to involuntary civil commitment. Section 9 is still considered by many health professionals to be ambiguous and a barrier to acting decisively.

If it is not possible to arrange for the elderly person to be voluntarily examined by a physician, Sections 10 and 11 provide means by which the examination can be arranged. Section 10 sets out the procedure before the Justice of the Peace who has the discretion to issue an Order for Assessment after which the elderly person may be forced to submit to an examination by a physician. Section 11 empowers a constable or other peace officer, under certain circumstances, to take the elderly person into custody and then to an appropriate place for initial assessment by a physician (usually to the Queen Street Mental Health Centre).

Service providers report that, in practical terms it is usually very difficult to use Sections 10 and 11, even when the facts of the situation seem to meet the standard set by the statute, because justice officials do not seem to be clear about the extent of their powers or responsibilities and are hesitant to make decisions about the care and hospitalization of elderly persons under Sections 10 and 11.

Admittance under this Act requires that the elderly person must be considered to be suffering from a mental disorder, i.e., a mental "disease" or "disability". A serious gap in service results from the diagnostic gray areas dividing mental and physical illness. As a result, the same symptoms in an elderly person are judged differently by the two institutions, and the person gets assistance from neither.

The Mental Incompetency Act

The present Act sets up an "all or nothing" format for declaring someone to be a "mentally incompetent person". Presently, the Act does not take into account degrees of competence in an area, or competence in certain areas but not in others. Anyone may apply to a court to be appointed or to have someone else appointed committee (guardian) of the "person" of an individual and/or of the "estate" of an individual and once someone is found to be mentally incompetent then that individual is considered to require "care, supervision and control" in all respects.

The Public Health Act

Powers of intervention under this Act extend to situations where a person maintains premises in a manner which may be considered to be a "nuisance" to the community or where there is "reasonable ground" to believe it is necessary to enter "for the administration of this Act or the regulations", i.e., for the public good.

Several sections of this Act are used to require improvements in the living conditions of seniors known as "hoarders". Two practical problems arise. Firstly, although the occupant is responsible for the mess, the burden of paying for clean-up falls on the owner of the property. Secondly, the hoarder's pattern of behaviour is often repetitive requiring the repeated involvement of public health officials, i.e., there appears to be no long-term solution.

B. CASE PROFILES: MARY AND RUBY

Taken from public health nurses' files, these two examples are used to illustrate the scope of intervention available to public health personnel. Some questions that are difficult to answer are raised:

1) If this Department must discontinue one-to-one treatment then who's going to be there when Marys and Rubys are caught in a service gap?

2) What should this Department be doing to ensure that elderly people are adequately served?

3) What program changes have to be made to bring Departmental practice closer to Departmental policy?

C. LAW REFORM

Guardianship Legislation

This Report's support for new guardianship legislation is qualified. The trend toward institutionalization will continue as long as community-based care options exist primarily on paper as is the case for the City of Toronto. Unless this Province puts money where its mouth has been, legislative reform will amount only to window dressing.

In cases where services have been refused and service providers are convinced it is desirable to impose care, we are really discussing <u>involuntary</u> guardianship, be it partial or complete, and therein lies the concern as to civil or human rights.

Presently in Ontario, it is not a sufficient ground for intervention to be able to show there is a threat to the person's health; the threat must result from an apparent mental disorder. Broader definitions which have been proposed would remove this requirement. Under such new legislation, we run the risk of having institutionalization used at an earlier stage than would otherwise be possible thereby serving to discourage the development of community-based care. But on the other hand, without access to temporary, partial guardianship, care needed to prevent unnecessary degeneration cannot be given unless the elderly person consents.

Local Board of Health

April 26, 1982

In the course of developing new guardianship legislation, it is important that:

1) due process is guaranteed;

2) definitions as to who is subject to guardianship must be carefully scrutinized; and

3) guardianship legislation must not be seen as the cure-all in providing health care to elderly people.

The Proposed Health Protection Act

The draft legislation provides the Medical Officer of Health with the power to insist that an individual receive medical assistance. This Department does not consider it appropriate for public health personnel to act as committees (guardians) or to have powers of intervention in the medical sphere.

PART II

WELFARE OF THE ELDERLY: A DEPARTMENT OF PUBLIC HEALTH PRIORITY

Departmental reorganization will create structures which facilitate an interdisciplinary approach to health services, and the elderly are likely to benefit from this. Public health nurses are already serving as primary health care providers to many elderly people, and, in two of the existing districts, Parkdale and Runnymede, an elderly at risk program is underway.

Ward Nine Senior Link and nurses in the Eastern Health Area work together as a concrete example of how the policy in Public Health in the 1980's can be applied in service delivery to elderly people.

The Department should be prepared to:

a) embark on an ambitious program to assist in training staff and volunteers of existing community agencies to monitor health status and provide one-to-one treatment to elderly residents;

b) transfer individual treatment responsibility to appropriate local agencies but continue to be available for advice and consultation; and

c) expand its advocacy role in areas where the need for services to the elderly is great but where directly serving that need is not an appropriate use of public health personnel.

The Department endorses Recommendations 4, 5, 6, 7, and 9 of a report from the Provincial Task Force on Aging entitled The Elderly in Ontario: An Agenda for the 80's which strongly support the increase of home care and home support services. However, the Department disagrees with the Provincial Task Force that major program changes are not "an immediate requirement".

An investigation into medical aid alarms is beyond the scope of this Report but reference is made to a study which postulates that only elderly people who are severely disabled but not socially isolated derive substantial benefit from such an alert system (1).

PART III

RECOMMENDATIONS:

1. That the Local Board of Health support the introduction of new guardianship legislation providing for partial as well as complete guardianship in the context of the least restrictive alternative and that the Health Advocate initiate discussions with the appropriate officials in the Ministries of Health, Community and Social Services, and the Attorney General to ensure that consideration is given to concerns expressed in this Report, prior to the introduction of legislation.

2. That the Local Board of Health indicate to the Minister of Health and the Metropolitan Toronto District Health Council its strong support for implementation of chronic home care programs in the City of Toronto within the next twelve months (by May, 1983).

3. That the Local Board of Health recognize advocacy efforts begun by members of the Mayor's Committee on Aging to bring chronic home care services to Toronto as soon as possible and that the Local Board of Health request that its Chairman communicate to the Committee that the Board is willing to cooperate in such advocacy efforts.

4. That a Task Force on Public Health Services to Elderly People be established, to be composed of two Local Board of Health members, one of whom will act as the Chairperson, the Health Advocate, two representatives from Public Health Nursing, a representative from the Mayor's Committee on Aging and others whom the Task Force may choose to appoint.

5. That the Task Force immediately begin meeting on a regular basis to establish the policy issues which it is going to examine in the context of Public Health in the 1980's and that the Task Force make its initial report to the Local Board of Health at its meeting on Tuesday, June 22, 1982.

Local Board of Health April 26, 1982

REPORT

CARE OF ELDERLY PERSONS WHO REFUSE HEALTH SUPPORT SERVICES

INTRODUCTION

This Report was begun at the request of the Local Board of Health in January of this year. The three separate motions which gave rise to the Board's request set out the parameters of this Report as being a response from the Medical Officer of Health to:

a) a letter from the Association of Women Electors of Metropolitan Toronto dated November 17, 1980; and

b) the May 12, 1981 report from the Commissioner of Planning and Development resulting from the inquest into the death of Miss Lillian Hess.

In her letter to the Local Board of Health, the President of the Association of Women Electors was of the opinion that the Department of Public Health is authorized to take action under The Mental Health Act and The Mental Incompetency Act when an elderly person refuses health support services. Two clear questions were put to the Board by the Association.

1) Have public health nurses been informed of permitted actions under these Acts?

2) Has the welfare of the elderly been made a priority in the Departmental reorganization?

Although each of these questions may partially be answered in the affirmative, such a response would belie the complexity of the policy and practice of the Department regarding elderly refusers of services.

The report from the Commissioner of Planning and Development made two specific recommendations pertaining to this Department:

> "3. That the Medical Officer of Health be requested to report on means of implementing a twenty-four hour emergency response service.
>
> "4) That the Medical Officer of Health be requested to report on the advocacy role that Department could take concerning the needs of an aging population."

Dr. G. W. O. Moss, the former Medical Officer of Health, forwarded "an initial response" to recommendations 3 and 4 of the Planning and Development report on July 7, 1981, and further Departmental response can be found in Part II of this Report.

Before proceeding with detailed responses to the foregoing questions, let us look at the context within which this Department's programs are being developed. Since November 28, 1978, the document entitled Public Health in the 1980's, has embodied the policy direction of this Department, supported unanimously by City Council on December 18, 1978. This means that program development and changes must reflect, in practice, the principles adopted by both the Local Board of Health and City Council. Of particular relevance to this Report is the following excerpt from page 37 of Public Health in the 1980's (underlining emphasis added):

"A second major goal is to build a Department which can resist the pressure to be all things to all people. This means reducing the Department's propensity to assume responsibility for all health-related problems which other agencies can't or won't handle. Roles proper to public health must be defined by policy, not through expediency.

"a) The implication of this position is not the abandonment of real treatment needs in the community because they don't fit into Department policy, but rather the diversion of our limited energy toward the primary prevention of problems. The Department will, of course, continue to mobilize necessary service (treatment) programs to deal with urgent health problems--but in a gap-filling role only, and for a very limited program life. Given the goals and resources of public health, a one-to-one treatment pattern (except on a short-term basis) is simply not feasible; moreover, maintenance of that pattern tends to maintain the problems. For example, public health nurses find themselves on an endless merry-go-round in finding sources of help for isolated, senile elderly people. Clearly, the problem exists on a societal level; we waste time, money, and effort trying to solve it on an individual level alone.

"b) Consequently, we must recognize that one of the major roles of public health is a political one: active advocacy for the correction of flaws in our health system, defined in the broadest sense. The notion that public health can be politically neutral was clearly discounted years ago, and is wholly unreasonable in the era of asbestosis and Minimata disease."

The gap between this goal and the Department's practice in the three and a half years since Public Health in the 1980's was adopted remains substantial. However, in the second part of this Report, examples of the Department's achievements in developing an orderly and humane transition demonstrate that progress is being made. It is probable that progress has to proceed at a measured pace in order to ensure that realistic alternatives are in place before long-term individual care by Department staff can be discontinued.

This Report has been written in three main parts. Using the questions put to the Local Board of Health by the Association of Women Electors as a guide, parts I and II have been entitled:

I Statutory Powers of Intervention in Public Health Matters as Related to the Elderly;

II Welfare of the Elderly: A Department of Public Health Priority.

Part III will contain specific recommendations.

PART I

STATUTORY POWERS OF INTERVENTION IN PUBLIC HEALTH MATTERS AS RELATED TO THE ELDERLY

There exists a substantial difference of opinion among health care professionals as to the adequacy of current statutory powers of intervention. Easier access to means by which the elderly refuser of services could be made to receive at-home and/or institutional care would likely require amendments to legislation.

On one hand, those who favour changes in legislation refer to a need for:

a) broader and clearer terms under The Mental Health Act defining when a person may be involuntarily committed to a mental hospital;

b) easier access to services currently offered by the Office of the Public Trustee so that the Public Trustee can more readily be given authority to administer the elderly person's property interests;

c) new guardianship legislation creating methods of obtaining authority to administer the personal needs, such as housing, medical treatment and lifestyle modification of persons who are unable to care properly for themselves and who refuse health support services.

On the other hand, concern has been expressed that even if legislative change is part of the solution it is only a small part and existing avenues of service under present legislation are not being utilized effectively. The potential for discrepancy between the service ideal outlined in legislation and the unintended reality of the actual service has also been raised. For example, an elderly person whose mental and physical state has deteriorated to the point where he or she badly needs home nursing care and house-keeping assistance could instead be forced to leave his or her home because community-based services do not exist in many parts of Toronto. If the services do not exist but a broader power of statutory intervention does, then it seems likely that the intervention will occur and the elderly person will be referred to whatever service is actually available: an institution.

Before beginning a discussion of current legislation, it is worth noting that the terms used, often interchangeably, to describe the elderly people in question - recluse, hoarder, refuser of service, mentally incompetent person, certifiable person, elderly at risk, disadvantaged adult - are in fact quite different from each other.

For example, a refuser of service is often not a recluse. Nor is a refuser of service necessarily someone who could be found to be mentally incompetent or certifiable and therefore subject to involuntary institutionalization under current legislation.

However, the characteristics of people who fit these descriptions often overlap and so it is perhaps understandable that the terms have come to attain a certain synonymity. In the course of this Report, an attempt has been made to distinguish these terms so that the descriptions may be used with more accuracy.

A. EXISTING STATUTES

The Mental Health Act, The Mental Incompetency Act, and The Public Health Act, are provincial statutes which all appear to provide for intervention in their subjects' lives, once certain conditions have been met. It is how these preconditions have been interpreted to limit what can be done by members of the Department of Public Health (and other service agencies) that has led to cries for legislative reform.

Because the Association of Women Electors in its President's letter to the Local Board of Health was of the opinion that "the Mental Health Act and the Mental Incompetency Act enable the Department of Public Health to take action in the case where an elderly person refuses health support services", it seemed desirable to examine what actually can be done under these statutes. It is not the purpose of this report to be the definitive legal statement on procedures, but rather to increase understanding about this legislation. For this reason, the summaries of the statutes discussed have been generalized and should not be relied upon in lieu of the statutes themselves.

1. The Mental Health Act (R.S.O. 1980, c.262)

Ordinarily, a person has the right to refuse services even when the service providers are convinced that the person is in dire need of those services. This Act is designed to provide for appropriate psychiatric treatment of a mental disorder. If an individual is suffering from a mental disease or disability, she or he may seek treatment under this Act through voluntary committal.

Involuntary Committal

But where an individual is so suffering and refuses services, certain treatment may be imposed on that person, once the person has been certified and involuntarily committed to a psychiatric facility. If consent to treatment, by or on behalf of an involuntary patient, cannot be obtained, application has to be made to a Regional Review Board which can order the giving of psychiatric treatment.

Sections 9, 10 and 11 of the Act are key to the process of involuntary committal and have been reproduced in Appendix A. An individual may be "certified" under this Act where there is "reasonable cause to believe" that the person is apparently suffering from a mental disorder (defined as a "disease" or "disability" of the mind) likely to result in behaviour injurious to themselves and/or to others OR likely to result in imminent and serious impairment of their person.

Examination by a Physician

A personal examination by a physician who must sign an application (Form 1) on the reasonable belief the person fits the foregoing description is a prerequisite for involuntary civil commitment. Section 9 describes the circumstances under which Form 1 may be signed by a physician.

For seven days after the physican has signed Form 1, it is sufficient authority to take the person in question to a psychiatric facility, and restrain, observe and examine the person there for a maximum of five days. To continue involuntary detention, another physician must give an opinion and decide to complete a Certificate of Involuntary Admission (Form 3).

Although this Act was amended in 1978 to clarify the criteria for commitment by more specifically describing the nature of the evidence required and the grounds for action by a physician, Section 9 is still considered by many physicians to be ambiguous and a barrier to acting decisively.

Where a person will not agree to an examination by a physician, Sections 10 and 11 provide the following means by which the examination may be arranged:

a) Section 10 of the Act allows friends, neighbours, relatives or others associated with the individual to go before a Justice of the Peace and provide evidence that the person has behaved or is behaving in one of three

generally described ways. Then the Justice of the Peace (at his/her discretion) may issue an Order for Assessment if the Justice of the Peace is satisfied that the person fits the description in Section 10. The person can then be forced to submit to an examination by a physician.

b) Section 11 of the Act empowers a constable or other peace officer who observes someone being "disorderly" AND who has taken into consideration the same standards as those considered by the Justice of the Peace, AND who is of the opinion that it would be dangerous to wait to obtain an assessment order from a Justice of the Peace, may take the person into custody and then to "an appropriate place" (in Toronto, usually Queen Street Mental Health Centre) for initial assessment by a physician. The physician must determine, in accordance with Section 9 of the Act (discussed earlier) if the person should be detained.

Numerous service providers interviewed for this Report indicated they have experienced considerable hesitancy on the part of Justices of the Peace and police officers to make decisions about care and hospitalization of elderly persons under Sections 10 and 11 of this Act. It is, in practical terms, therefore usually very difficult to use these sections, even when the facts of the situation seem to meet the standards set by the statute.

Limitations of this Act

A review of these sections demonstrates of what limited use this Act can be. No authority is given to public health staff, with the possible exception of physicians, to take special action under this statute. This Department does not consider it appropriate for public health physicians to perform personal examinations under this Act except in extraordinary circumstances. The only "service" available to the elderly person who refuses care is involuntary committal to a psychiatric facility. To be eligible for this service, the elderly person must first be considered to be suffering from a mental disorder, i.e., a mental disease or disability. Clearly this is not a statute with provisions for "at-home" or "preventive" care although satellites of Queen Street Mental Health Centre sometimes are able to provide such services. Furthermore, diagnostic gray areas dividing mental illness from physical illness or deterioration create confusion and in turn a serious gap in service. Hospitals refuse to admit some elderly people because they are diagnosed as mentally, not physically, ill and psychiatric facilities refuse admittance

on the grounds that the person is physically, not mentally, ill. Because the same symptoms in an elderly person are judged differently by the two institutions, the person gets assistance from neither.

2. The Mental Incompetency Act (R.S.O. 1980, c.264)

Under this Act anyone may apply to a court to be appointed or to have someone else appointed committee (guardian) of the "person" of an individual and/or of the "estate" of an individual. Guardianship is principally a legal device used to give to someone certain powers over another individual when that individual is considered (on the basis of the quasi-medical diagnosis of "mentally incompetent") to be unable to bring adequate personal judgment to the exercise of all or some of the rights pertaining to adults in our society. The distinction between person and estate is basically one between care, supervision and control over decisions related to a person's health, housing or specific medical treatment as compared to decision-making involved in the protection of a person's property (bank accounts, real estate, etc.). In Ontario, someone acting as committee (the Public Trustee, for example) often makes the decision to, for instance, place a mentally incompetent person in a psychiatric facility or hospital. Such decisions relate to the "person" much more than they do to the "estate" of the person. The Act is not clear in defining the extent of a committee's authority. For example, although it is done in practice, it is not certain from a reading of the Act whether the committee's authority to detain the person can be transferred to an institution to which the committee chooses to send the person. Nor is the distinction between "person" and "estate" as clear as it should be.

Recently, this Act has been scrutinized by the Provincial government and other organizations concerned with seniors who have called for legislative reform in the area of guardianship. It has been noted that the present Act sets up an "all or nothing" format which does not take into account degrees of competence in an area, or competence in certain areas but not in others. Rather, once someone is found to be a "mentally incompetent person" then that individual is considered to require "care, supervision and control" in all respects.

It is of interest to note that the court may not by order declare a person a mentally incompetent person unless the evidence before the court establishes "beyond reasonable doubt" the person's mental incompetency. This is the standard

of proof normally reserved for criminal matters, but because such basic individual rights are at issue in a guardianship proceeding, this high standard is maintained even though it is not a criminal matter. This puts considerable onus on those applying to inform the court fully in order to obtain a declaration that a person is a "mentally incompetent person". The onus sometimes creates difficulty for those applying in gathering sufficient evidence. As well, such court proceedings are often lengthy and somewhat expensive. It is the tension between respecting individual rights and promoting the public good which has prompted recommendations that better defined, administratively streamlined procedures are needed. Later in this Report, the concept of "partial guardianship" will be discussed.

At present, there are no special provisions enabling public health personnel to intervene when an elderly person refuses care other than to facilitate, without breaching confidentiality, an application under this Act to have the Public Trustee or some other individual named as committee of both the person and the person's estate. This Department does not consider it appropriate for public health personnel to act as committees or to have powers of intervention in the medical sphere. Public health, by its very definition and certainly by the terms of Public Health in the 1980's and The Public Health Act, is primarily concerned with protection of the well-being of the community.

3. The Public Health Act (R.S.O. 1980, c. 409)

Powers of intervention under this Act extend to situations where a person maintains his or her premises in a manner which may be considered to be a "nuisance" to the community, as defined by sections 116 and 117 of the Act. Entry to "any premises" by the Medical Officer of Health or an employee acting under instructions from the Medical Officer of Health is allowed to "inspect and examine the premises for the purposes of carrying out this Act". As well, subsection 2 of section 4 sets out the procedure to obtain an order authorizing entry for a public health inspector who is not operating under the "nuisance" provisions when there is "reasonable ground" to believe it is necessary to enter "for the administration of this Act or the regulations".

Sometimes the living conditions of an elderly person constitute the most apparent danger to public health. These seniors are often referred to as "hoarders" because they have accumulated so much with which they refuse to part, often including garbage. Should the senior refuse to take any

action to improve those conditions, section 122 may be used by the Medical Officer of Health. Subsection 2 of section 122 provides that having found premises to be in a "filthy or unclean state or having therein any matter or thing...that...may endanger the public health", the Medical Officer of Health may order the "owner or occupant" to rectify the situation. If the order is ignored, section 128 empowers the Medical Officer of Health or a public health inspector to "enter the premises and take such steps as may be necessary to abate" the nuisance. The costs of removal and clean-up are added to the municipal taxes. Under the current Act, a practical difficulty often arises when the hoarder is an occupant and not the owner. Because the taxes are the responsibility of the owner and because the elderly occupant often does not have much money, the burden of paying falls on the owner and as a result, the elderly hoarder may lose his or her residence--hardly a solution to the original problem! As well, a hoarder's pattern of behaviour is often repetitive so that intervention by public health officials has to be repeated.

B. CASE PROFILES: MARY AND RUBY

Service providers are seldom involved in the formulation of legislation and policies which govern their day to day work. Yet it is the service provider who most often experiences the transition from the abstract to the concrete: an individual client in crisis. This Report began with reference to the principles enunciated in Public Health in the 1980's and it is well known that we, as a Department, are in the midst of a reorganization that is based on those principles. These two profiles should serve to illustrate the challenge which faces both those who develop policy and those who are on the "front lines".

1. Mary

Mary (not her real name) is in her mid 80's, owns two homes in downtown Toronto (one is abandoned and she lived in the other for over 20 years). She appears to have no next-of-kin in Toronto. Until recently, Mary's choice of lifestyle included these features:

- living alone with 12 dogs, all very dear to her;
- no running water (carried her water from a neighbour several houses away);

- no central heating (chopped her own wood and slept in the same area as the stove);
- hoarding of belongings and garbage;
- conditions which would generally be considered unsanitary, generating strong odours.

The public health nurse has been involved with Mary for approximately six years and describes her as having been generally pleasant, not refusing access but not attentive to her own personal needs nor receptive to suggestions as to her personal care. Over the years, inspectors from the Food Control and Sanitation Division and inspectors from the Fire Department found Mary unreceptive to legal requirements that she carry out the necessary repairs and cleaning operations to meet housing standards. By accepted standards, Mary's choice of lifestyle was not "normal" but the service providers, including a psychiatrist who performed an assessment, did not consider Mary to be mentally incompetent under the terms of The Mental Incompetency Act or certifiable under The Mental Health Act. Once those determinations were made, the only remaining means of statutory intervention was through The Public Health Act, a statute designed for intervention in the interests of the community rather than an individual. Furthermore, unless Mary had one of the communicable diseases covered by this Act, neither the public health inspector nor the public health nurse would have had any authority over her person.

Toronto experienced some of the coldest winter days in recent history during the month of January this year and Mary found it difficult to chop enough wood to keep a supply for her little stove. As was perhaps inevitable, Mary awoke one Sunday morning in subzero weather and discovered that she had no chopped wood on hand.

As she put it:

> "I was too cold and tired to get up, go outside, chop the wood, come back in and get a fire going so I just stayed in bed until the young fellow from Meals-on-Wheels came by around noon. When I got to the door, he had one of those friendly faces and he asked me how I was feeling. Normally, I just say: "Very well, thank you", but that day I answered: "Horrendous". He asked me if there was anyone he could call and I told him to call public health..."

The public health nurse, having anticipated just such an emergency, had given Mary her home phone number but Mary was unable to find it so contact was made through the City Hall Information Desk and the nurse attended at Mary's home. The nurse called a representative from the Fire Department who brought some wood to Mary from his own home. Fortunately, Mary's imminent death was averted, but she had to be hospitalized with severe frostbite. Mary described the pain she experienced as a result as being "like nothing I have ever had since the birth of my daughter" (some 61 years ago). Mary is currently residing in a temporary apartment with her one remaining dog. Mary has begun to cooperate fully with her service providers and the public health nurse, the public health inspector and the Estates Officer from the Public Trustee (to whom she has recently given a Power of Attorney to handle her estate), are all on her list of favourite people. The Department of Public Health and the Office of the Public Trustee, having obtained Mary's voluntary cooperation, are now able to proceed with provisions to clean up and settle the properties.

2. Ruby

Ruby (not her real name) will be 82 this year. Unlike Mary, she has had a medical history of senile dementia and strokes. In 1978, Ruby was found to be a mentally incompetent person and since then, her estate has been controlled by the Public Trustee. Until recently, Ruby resided with her daughter. Although Ruby's daughter was not officially named committee (guardian) of Ruby's person, in practice she exercised control over her mother's care.

The public health nurses who have had Ruby as a client made several attempts over the years to place Ruby in a nursing home. Each time, Ruby's daughter either cancelled the plans or removed her mother from the nursing home. The public health nurse had observed Ruby's daughter to be inebriated when visiting and had often heard her voice to be slurred over the telephone. Staff members of various agencies reported that Ruby's daughter had been verbally abusive in telephone conversations. It was clear that the daughter's employment pattern was irregular and that financial insecurity greatly concerned her. Ruby's estate was minimal and the Public Trustee determined how any monies were to be expended, so the daughter did not have access to her mother's assets.

Community police records indicate a history of beatings which Ruby had reported to them prior to 1978. Ruby continued to allege that her daughter was beating her and that she feared

for her life, home and possessions. The police noted a considerable deterioration of Ruby's person since she first came to their attention.

Ruby had been seen at a local hospital's emergency department with injuries which she said were due to her daughter, but her daughter denied the accusations. Having been found to be a mentally incompetent person, any testimony which Ruby might have been able to give in court was not considered to be sufficient to form the basis of charges.

Unable to intervene, the public health nurse was faced with trying to fulfill her obligations to a client whose situation was best described by the following excerpt from the Nurse's Report, made some months ago:

> "At present, there exists a pattern of neglect, as well as the injuries noted above. Ruby is often left alone in the apartment, which condition is very unsafe in her confused mental state. At times she is undressed when others arrive, and one caretaker stated she had found Ruby out on the balcony. Her hydration and diet are questionable, although her daughter reports the opposite. At the time of last admission to X Nursing Home, the attending physician found Ruby dehydrated and malnourished on arrival, with a few bruises.
>
> "In her present deteriorating state, Ruby has become incontinent of bowel and bladder. Her daughter complains of the amount of care presently required by her mother, and can not, without substantial additional resources, provide adequate care to her mother at present.
>
> "Improvement in Ruby's condition is unlikely. Rather, in the normal course of events, she will deteriorate further and require more care."

Although several other agencies and professionals were involved with Ruby -- a social worker from the hospital, a nurse from a community satellite clinic of Queen Street Mental Health Centre, staff from X Nursing Home, a police constable from the local Division -- it was at the initiative of the public health nurse and her superiors, with the permission of the then Medical Officer of Health, that Ruby's predicament was ameliorated.

Discussions took place with officials of the Ministry of the Attorney General of Ontario who advised that a request should go from this Department to the Office of the Public Trustee urging the Public Trustee to obtain the necessary authority to act as committee of Ruby's person. This was done and shortly thereafter Ruby was removed from her daughter's care and placed in a nursing home.

3. Elderly At Risk

Both Ruby and Mary are members of a rapidly increasing group of seniors in our society known as the "elderly at risk". Current policy and legislation limitations make satisfactory and efficient resolution of these challenging cases very difficult for the service providers who come to know and care for these seniors as individuals. Lillian Hess was also clearly a member of the elderly at risk group, and like Mary, Lillian was not considered likely to be found to be a mentally incompetent person under The Mental Incompetency Act or certifiable for involuntary committal under The Mental Health Act.

In Ruby's case, the lack of clear procedures to be followed under the present guardianship statute, The Mental Incompetency Act, created confusion and uncertainty for the service providers who wished to take action but had difficulty determining the legal limits on what they could properly do. As well, no one agency had the definite responsibility to coordinate and follow through the various parts of assistance which presumably made up the whole service package. It is worth looking at the features which distinguish how these two cases were resolved:

1) Initiative was taken by the Department. In Mary's case, the public health nurse organized informal case conferences with other agencies. In Ruby's case, the public health nurse contacted the Public Trustee and other officials who had greater scope to act with authority and strongly encouraged them to use that authority to ensure that Ruby was safely placed.

2) The ongoing involvement, over years, of public health staff, resulted in a comprehensive overview of each woman's situation. Because Mary had remained mentally competent, the public health nurse and the public health inspector developed a relationship with Mary which, complemented by years of ground work laid by the public health nurse, allowed Mary to come to the decision to give Power of Attorney to the Public Trustee. The

response from public officials to her emergency that Sunday was a turning point for Mary: she knows she almost died and she knows who came to her assistance. In short, a growing trust relationship was consolidated.

Neither of these cases is atypical. Every supervisor of nursing in this Department has to consider what can be done on a case-by-case basis for many such Marys and Rubys. Interviews with service providers indicated that there exists a strong desire for clarified and streamlined procedures for response to a situation where an elderly person at risk is refusing services, including some guidance as to when it is appropriate to withdraw from a case.

These case studies raise some questions that are difficult to answer:

1) If Public Health in the 1980's dictates that this Department must discontinue much of the one-to-one treatment it has provided for years (treatment which it is expected to provide by clients, agencies and many community members) in order to create the staff time and energy to concentrate on primary care programs - keeping healthy people healthy - then who's going to be there when Marys and Rubys are caught in a service gap?

2) What can this Department do to ensure that members of the community who must rely on assistance in meeting their personal needs are served, even though it is not an appropriate use of public health personnel to meet those needs?

3) What program changes will have to be made to bring Departmental practice closer to Departmental policy enunciated in Public Health in the 1980's?

These questions will be addressed in Part II of this Report. Before proceeding to that discussion, however, let us examine the question of legislative reform.

C. LAW REFORM

1. Guardianship Legislation

There are numerous proponents of new guardianship legislation. The Ontario Advisory Council on Senior Citizens is on record proposing a new Guardianship Act "which would provide for a court supervised procedure for the protection of 'adults in need of protection' by means of a partial or complete guardianship, which is both temporary and flexible".

The Commissioner of Planning and Development, in his report to the Neighbourhoods Committee dated May 12, 1981, recommended:

> "That Council support the introduction of a provincial Guardianship Act which provides for partial or complete guardianship, and can be flexible in its application."

The former Medical Officer of Health in a report to the Neighbourhoods Committee, dated July 7, 1981, referred to proposed guardianship legislation and indicated that the Department of Public Health would support further "exploration and study of this possibility".

In October 1981, members of the Subcommittee on Aging of the Mayor's Task Force on Disabled and Elderly Persons supported the proposed Guardianship Act as set out by the Ontario Advisory Council for Senior Citizens.

Considerable policy discussion among the three Provincial Ministries which would be responsible for introducing guardianship legislation - Community and Social Services, Health, and the Attorney General - has taken place through an Interministerial Committee. This Committee has completed its report to the Ministries but it has not released it generally and it was not made available to this Department in the preparation of this Report.

Partial Guardianship

In essence, partial or limited guardianship occurs when a judge exercises discretion to place limitations on the powers of a guardian. There is a demonstrated trend in the United States towards new legislation which empowers judges to exercise such discretion. At present, only the Provinces of Alberta and Newfoundland have enacted similar legislation.

It seems logical that if policies placing maximum reliance on community-based forms of care are to be effectively implemented, then forms of guardianship must be tailored to respect an individual's actual capabilities. At present in Ontario, once guardianship is granted, it covers all aspects of "care, supervision and control".

A very practical point needs to be made here. Even with statutory provisions allowing partial guardianship as a means of facilitating community-based care, the trend toward institutionalization will continue as long as community-based care options exist primarily on paper, as is the case for Toronto. Legislative reform without policy and program changes will serve to deflect awareness from the main source of our social system's inadequacy in serving the elderly at risk: undeveloped and underdeveloped alternatives to institutions. Putting it bluntly, unless this Province puts money where its mouth has been, legislative reform will amount to window dressing, leaving service providers who believe in the alternatives in an ever-increasing quandary and elderly people in an ever-widening service gap.

Individual Rights

All of the proponents of the guardianship legislation referred to the need to balance statutory powers of intervention with respect for individual rights. It might be helpful to discuss briefly the actual nature of the "rights" which are generally acknowledged to exist, but seldom explored in any detail.

It should be borne in mind that in cases where services have been refused and service providers are convinced it is desirable to impose the care, we are really discussing involuntary guardianship, be it partial or complete, and therein lies the concern as to civil or human rights.

A legal analysis of this question is not within the scope of this Report but the following comments have been made to generate further consideration of the nature of reform which this Department and the Local Board of Health may choose to recommend. The Report concludes that:

1) due process should be guaranteed;

2) definitions must be scrutinized; and

3) guardianship legislation must not be seen as the cure-all.

Due Process

Present and proposed guardianship legislation should contain a balancing of governmental and individual interests by ensuring that the subject of the proceedings is always accorded "due process". Therefore it must be spelled out in the legislation rather than left subject to a judge's discretion. In common sense terms, this means that the subjects of the proceedings must be treated fairly. A hearing should not be one-sided. In practical terms, for two sides to be heard, the alleged incompetent should have: a) reasonable advance notice; b) the right to be heard; and c) the right to be told, in advance of the hearing, that he/she has the right to be represented at the hearing by counsel of his/her choice. As well, the right to appeal and the process of appeal should be delineated in the statute. A guardianship order should not be everlasting. For example, Great Britain, Alberta, and in some cases Ontario have specified limits on the life of guardianship orders.

Serious attention needs to be paid to the role of the Public Trustee. In Ontario, it is not clear whether a person without financial means can choose counsel or whether the person must accept representation by the court appointed Public Trustee.

Definitions

Definitions as to who is eligible for "protection" are crucial. A broad definition casts a broad net. For example, the Ontario Advisory Council on Senior Citizens has proposed the following draft definition:

> "In determining whether or not a person is a Person who is an 'adult in need of protection' thus rendering him at risk within his environment, consideration shall be given to the following:
>
> "a. Is he unable to maintain himself in daily living?
>
> "b. Does he have any psycho-social problems, such as severe memory loss?
>
> "c. Is he able to handle his own financial affairs?
>
> "d. Is he in need of legal protection?
>
> "e. Does he require protection from economic exploitation?

"f. Does he have any medical or functional problems making him unable to cope with his environment, for example, does he have lessened mobility?"

Another example of an expanded definition comes from the National Assistance Act of Great Britain for persons who:

"are suffering from grave chronic illness or, being aged, infirm or physically incapacitated, are living in unsanitary conditions and are unable to devote to themselves proper care and attention".

Under this statute, an appropriate authority can apply to a court for an order for removal of such a person to a suitable place for detention and maintenance therein, for up to 3 months.

The State of California has redefined "incompetent" as:

"any adult person who, in case of a guardianship of the person, is unable properly to provide for his own personal needs for physical health, food, clothing, or shelter, and, in the case of a guardianship of the estate, is substantially unable to manage his own financial resources."

In Ontario, it is not sufficient grounds for intervention to be able to show there is a threat to the person's health; the threat must result from an apparent mental disorder.

An important distinction must be drawn between definitions used currently in Ontario (The Mental Incompetency Act and The Mental Health Act) whereby the showing of mental disorder is a prerequisite and the three alternative definitions quoted above whereby there is no requirement to show mental disorder. In all three alternative definitions, a standard of inability to manage personal or financial affairs due to any cause is explicitly adopted. The current Ontario definitions apply to a much smaller segment of the population than would these broader definitions.

The Impact Of New Legislation

Finally, we come to the question of whether new guardianship legislation can help to provide better services along the continuum of care which stretches from an individual's complete independence to institutionalization in a chronic care facility. One view is that by making it easier to gain such control over another's life, we run the risk of having

institutionalization used at an earlier stage than would otherwise be possible thereby serving to discourage the development of greater opportunities for an elderly person to remain within the community. Alternatively, it has been argued that in order to provide services necessary to allow an elderly person his/her preference of remaining in the community, limited or partial guardianship should be available to ensure that care needed to prevent unnecessary degeneration is received, even if not wanted. For example, Mary could have come under one of the three broader definitions quoted at the beginning of this section, her property sorted out, her house cleaned up, and maybe, depending on the judgement of the service providers and the availability of home support services her living situation in the community improved - all without the trauma of that Sunday and its consequences, and well before six years had elapsed. It is arguable that Lillian Hess would have benefitted from legislation which allowed service providers to override her decision to refuse care. And it seems clear that Ruby would have been placed safely at a much earlier date had the legislation provided a clear and workable procedure which could have been initiated by health professionals as soon as Ruby's predicament was apparent.

In Alberta, The Dependent Adults Act established the position of Public Guardian, and provided for "plenary" (complete) as well as "partial" guardianship of the person as being distinct from trusteeship of the person's estate. Section 6(1) of The Dependent Adults Act provides that:

> "Where the Court is satisfied that a person named in an application for an order appointing a guardian is
>
> "(a) 18 years of age or older,
>
> (b) unable
>
> (i) to care for himself, and
>
> (ii) to make reasonable judgements in respect of all or any of the matters relating to his person,
>
> "and
>
> "(c) in need of a guardian,
>
> the Court may make an order appointing a plenary guardian or a partial guardian."

The procedures introduced by this statute have proven to be usable. Since enactment, the Province of Alberta has experienced a burgeoning of applications under this Act.

Clearly there are implications which have to be considered in the context of Ontario such as cost of establishment of facilities and services available to this increased population of "protected" persons to ensure that premature institutionalization is minimized. Ontario must also decide whether it will follow the Alberta model by creating an Office of the Public Guardian with authority over the "person", leaving only the authority over the "estate" to the Public Trustee.

2. The Proposed Health Protection Act

Reference to this potential legislation will be brief as it is not yet clear that the draft statute will be introduced into the Ontario Legislature in the form which is presently available to this Department.

The proposed section 14 of the draft reads:

> "Where a medical officer of health is of the opinion, upon reasonable and probable grounds, that a person residing in the health unit served by the medical officer of health shows a lack of competence to care for himself and that serious physical impairment of the person is imminent, the medical officer of health may provide or arrange for medical attendance, medicine and other assistance and necessaries for the person."

A request has already gone to the Ministry of Health from the Local Board of Health and City Council to re-examine this section. This communication noted, in part, that:

> "Section 14 dealing with persons in need provides the Medical Officer of Health with the power to insist that an individual receive medical assistance. If this is the case, the Medical Officer of Health assumes discretionary authority which may be quite inappropriate, and leads to an interference with individual rights. Where is the mechanism for certification of incompetence, and what appeal mechanism is in place?"

II WELFARE OF THE ELDERLY: A DEPARTMENT OF PUBLIC HEALTH PRIORITY

A. REORGANIZATION

In her letter to the Local Board of Health, the President of the Assocation of Women Electors of Metropolitan Toronto indicated:

> "We would also be interested to know if the welfare of the elderly is being made a priority in the Departmental reorganization."

One of the purposes of reorganization is to create structures which facilitate an interdisciplinary approach to health services.

As illustrated earlier in this Report, practical responses to the needs of the elderly have on occasion given rise to a "de facto" interdisciplinary approach, very often coordinated by the public health nurse. As evidenced by a May 12, 1981 report to the Local Board of Health from the Public Health Nursing Division, public health nurses are already serving as primary health care providers to many elderly people. Present public health nursing services to seniors may be summarized as: assessing the person's situation; providing appropriate health counselling or teaching; mobilizing family and/or community services; coordinating the resulting activities and monitoring the person's functioning to the point where the person becomes self-directing, or to where there is a need for transfer to other health care facilities.

In two of the Department's existing districts, Parkdale and Runnymede, a program focused on the elderly at risk is continuing. The target group of "elderly at risk" is defined for the purposes of this program as: elderly who live alone; manifest transient confusion and/or short-term memory loss; are socially isolated; and have poor health.

The service consists of assessment, referral and monitoring through home visits and liaison with the geriatric unit at Queen Elizabeth Hospital as well as with other community agencies. An internal evaluation of this program has recently been completed and its extension to the new Health Areas, with appropriate modifications, will be considered.

Because the Eastern Health Area was established as the first phase of the current reorganization, we can look to it to provide a concrete example of how the policy of Public Health

in the 1980's can be applied in service delivery to elderly people. Where community-based support services are inadequate or do not exist, the only practical solution is to help to create those services. Happily, there is evidence that Ward Nine Senior Link - a nonprofit home support agency serving the elderly - and personnel from the Eastern Health Area have a working relationship which is consistent with Public Health in the 1980's and which provides thorough, compassionate home care. Very often, the public health nurse will make a referral to Senior Link and the agency is able to take over the role of monitoring the elderly person's health status, to the extent of several visits a day, seven days a week where required. The agency is able to send in someone to prepare meals and to stay with the elderly person to ensure that the meal is eaten and to provide social contact to alleviate isolation. When the Senior Link representative notices a change or deterioration in the person's condition then the public health nurse is contacted and s/he is able to visit the person to do an assessment and to consult with Senior Link as to the best next step.

Senior Link describes itself as: "Staffed with professionals, the agency provides directly, or facilitates through volunteers, the essential support services which allow our seniors to remain in their homes. Where intensive care is needed, it's available. Daily phone calls, or meals thrice daily, provision of medicine and other care required but not provided by friends, relatives or government agencies." In short, Senior Link is doing today what many public health nurses used to do - and what many public health nurses and sometimes other Department staff are still doing.

As reorganization proceeds, there will be much opportunity for managers in the other Health Areas to expand upon what is being done in the Eastern Health Area. Where local agencies similar to Senior Link do not exist or are not well-developed, Department personnel should be prepared to support and facilitate community efforts to build or improve on such agencies. For example, public health nurses could assist in the training of staff and volunteers of local agencies to be able to monitor developments in an elderly person's health and to judge when additional assistance is needed. As well, nursing services designed to provide individual home care (Victorian Order of Nurses; St. Elizabeth Nurses) can be called upon instead of public health nurses to provide direct treatment on a one-to-one basis.

1. Best Use of Resources

Certain Departmental Divisions represent particular areas of expertise in health care delivery and while it is important to identify service gaps and respond to them in a manner consistent with policy, it is also important for the Department to remain clear on who should be doing what in accordance with particular skills. It is the coordination of these skills based on overall goals which reorganization is designed to catalyze.

Let's return to the quotation from this Department's chief policy document used earlier in this Report:

> "A second major goal is to build a Department which can resist the pressure to be all things to all people. This means reducing the Department's propensity to assume responsibility for all health-related problems which other agencies can't or won't handle. Roles proper to public health must be defined by policy, not through expediency.
>
> "a) The implication of this position is not the abandonment of real treatment needs in the community because they don't fit into Departmental policy, but rather the diversion of our limited energy toward the primary prevention of problems. The Department will, of course, continue to mobilize necessary service (treatment) programs to deal with urgent health problems -- but in a gap-filling role only, and for a very limited program life. Given the goals and resources of public health, a one-to-one treatment pattern (except on a short-term basis) is simply not feasible; moreover, maintenance of that pattern tends to maintain the problems. For example, public health nurses find themselves on an endless merry-go-round in finding sources of help for isolated, senile elderly people. Clearly, the problem exists on a societal level; we waste time, money, and effort trying to solve it on an individual level alone."

This is a statement with a vision which is echoed in this Department's subsequent discussion papers on community care and support.

Most of the Department's policy in this area is in the developmental stage but it seemed pertinent to this Report to

summarize some of the tentative conclusions reached in a recent discussion paper prepared by Dr. Trevor Hancock and Ms. Rebecca Metcalfe-Harris:

1) This Department cannot undertake responsibility for active treatment home care.

2) There needs to be a further cutback in certain functions presently carried out by Department staff, for example, friendly visiting of elderly people, to allow more time for primary prevention, but the cutback must be done in a humane and orderly fashion.

3) This Department must further develop criteria for accepting or refusing referrals so that ineffective and inefficient use of the skills of Departmental staff is reduced and so that staff do not bear the brunt of ambiguous policy guidelines.

In the recently released report, The Elderly In Ontario: An Agenda For The '80's, the Provincial Task Force on Aging recommended strongly that home care and home support services should be increased, stating:

> "Recommendation 4. The Province should continue to support alternatives to acute hospital care with priority on long-term care and community services.
>
> "Recommendation 5. The Province should support the development of demonstration projects in innovative health care for the elderly (e.g. day programs, outpatient programs and community based health clinics), and in applied research related to the elderly and their utilization patterns.
>
> "Recommendation 6. The Province should continue to apply a high priority to development of home care and home support services.
>
> "Recommendation 7. The Province should develop a strategy for the provision of coordinated on-site health and social support services to residential clusters of the elderly with initial priority to senior citizens residences.
>
> "Recommendation 9. The Province should encourage coordination in local planning for the elderly." (underlining added).

The overall goal of the Department to use our resources for primary prevention so as to enable seniors to remain in the community for as long as possible will be enhanced should the Province adopt the recommendations above. However, the Provincial Task Force also concluded that "the Ontario Government is not faced with an immediate requirement for major program changes to respond to demographic shifts." With all due respect, the Task Force seems to have seriously underestimated the urgent need in the City of Toronto for drastically expanded community-based support services; chronic home care in particular. The City of Toronto is experiencing very serious program deficiencies (even where programs exist) and the Task Force is simply wrong in concluding that there is no immediate need for major program changes.

B. SERVICE GAPS

1. 24-Hour Emergency Response

Recommendation 3 of the Planning and Development Department Report arising from Recommendations from the Lillian Hess inquest states:

> "That the Medical Officer of Health be requested to report on means of implementing a twenty-four hour emergency response service."

An initial response from the former Medical Officer of Health raised some points which can be summarized as follows:

- Most of the needs which arise on an after-hours emergency basis require the attention of a medical doctor and could not be handled by public health nurses or public health inspectors;

- There is a current emergency response system in place whereby senior public health inspectors and public health nurses are "on-call" should the person on duty at the City Hall Information Desk judge that a call received can be appropriately referred to either Division.

While both of these points are worth noting, consideration still needs to be given to how this Department should respond to this particular service gap so as to be consistent with Departmental policy.

The recommendation that the Department of Public Health should establish a 24-hour emergency response service originated with a local agency - The Community Information Centre of Metropolitan Toronto. Since 1977, a consultation process has been ongoing to develop an overview of after-hours services in Metro Toronto. There is a need to coordinate the delivery of human services outside of normal working hours in order to facilitate public access to these services in a cost-effective manner. Recently, the Community Information Centre has concluded that such a service need not be the responsibility of only one agency. Fortunately, the Department of Health and Welfare Canada has awarded a feasibility study grant to the Community Information Centre to explore further the concept of an after-hours central clearing house as a means to achieve coordinated access to after-hours services. This Department has indicated a willingness to be involved in consultations related to this study.

2. Medical Aid Alarms

As another alternative, it is worth considering whether there are other nonDepartmental services available which need not be brought under Departmental responsibility but could be incorporated successfully into ongoing programs. For example, the Department could be evaluating the utility of health care monitoring and emergency response systems such as those demonstrated to the Local Board of Health in January of this year. At that time, the Board passed a motion requesting that the Medical Officer of Health investigate medical aid alarms. Such an investigation is beyond the scope of this Report other than to suggest that such alarms may be one possible means of furthering independence for elderly people who are considered at risk and who might not otherwise be able to remain in their homes. A preliminary American study on such a system indicates that there may be important psychological characteristics distinguishing those who do from those who do not use such a service. This study's authors postulate that elderly people who are severely disabled but not socially isolated derive the greatest use and benefits from the alert system. Other than that generalization, the study does not appear to have demonstrated any greater degree of predictability as to use (1).

C. ADVOCACY

Recommendation 4 of the Planning and Development report stated:

> "That the Medical Officer of Health be requested to report on the advocacy role that Department could take concerning the needs of an aging population."

Earlier in the Planning and Development report it was observed that the machinery exists, in the existence of the advocacy position of the Coordinator for Disabled and Elderly (now further supported by the recent establishment of the Mayor's Committee on Aging) and in the Health Advocacy Unit, for carrying out a strong advocacy function for the elderly population at the City level.

It has also been pointed out that case-by-case advocacy is carried on daily by public health nurses, sometimes with the assistance of public health inspectors and mental health nurses from the Department. It is worth considering what additional support the Department can give to both existing and developing community-based services.

Many of the recommendations in this Report directly affect other levels of government. A strong advocacy role will be taken by this Department in order to generate the understanding and support for these proposals which will enable appropriate groups to make them realities.

PART III

RECOMMENDATIONS

A. GUARDIANSHIP

This Department is an important source of referral for elderly people who are in need of protection in the form of guardianship over their property and/or person. Sufficient concern over the unclear procedures and definitions in current legislation dealing with guardianship has been expressed by members of this Department that we have concluded new guardianship legislation to be a necessity. However, we firmly believe that such legislation should provide that a Judge deciding to grant powers of guardianship must first consider whether individuals in question are competent in any aspect of their person or estate. The Judge should be required to choose the alternative which is least restrictive to the individual, with emphasis on the least disruption to an elderly person's life. The principles of due process must be substantially respected in the new legislation. Of the possible models, the Alberta Dependent Adults Act embodies many of the principles which we consider to be essential. That statute established a separate officer (Public Guardian) responsible for guardianship of the person, leaving responsibity for guardianship of the estate to the Public Trustee. Such a distinction of responsibility seems highly desirable in that different skills and information are often required to make decisions as to necessary and least restrictive alternatives for an elderly person.

Recommendation:

1. That the Local Board of Health support the introduction of new guardianship legislation providing for partial as well as complete guardianship in the context of the least restrictive alternative and that the Health Advocate initiate discussions with the appropriate officials in the Ministries of Health, Community and Social Services, and the Attorney General to ensure that consideration is given to concerns expressed in this Report prior to the introduction of legislation.

B. COMMUNITY-BASED CARE

While direct home nursing or frequent monitoring on an individual basis cannot be considered to be an appropriate responsibility for public health personnel, the Department can help to facilitate the delivery of community-based care, both acute and chronic, to elderly people. We are gravely concerned that the immediate widespread inadequacy of community-based care for elderly people is not being addressed. New programs must be put in place at the local level as soon as is humanly possible. It is our understanding that the City of Toronto is scheduled to receive chronic home care services only after most other communities in this Province. The situation in Toronto must receive earlier attention than that. Home care for Toronto's elderly must be moved up on the Ministry's "Agenda for the 80's".

Recommendations:

2. That the Local Board of Health indicate to the Minister of Health and the Metropolitan Toronto District Health Council its strong support for implementation of chronic home care programs in the City of Toronto within the next twelve months (by May, 1983).

3. That the Local Board of Health recognize advocacy efforts begun by members of the Mayor's Committee on Aging to bring chronic home care services to Toronto as soon as possible and that the Local Board of Health request that its Chairman communicate to the Committee that the Board is willing to cooperate in such advocacy efforts.

C. TASK FORCE ON PUBLIC HEALTH SERVICES TO ELDERLY PEOPLE

Finally, because this Department is in the midst of reorganization and new program development, this is an ideal time to examine further the role of public health personnel in the delivery of health and social services to elderly people.

Public Health in the 1980's was generated through the collaboration of Local Board of Health members, Department of Public Health personnel, consultants and community. Similarly, but on a smaller scale, the policies on the delivery of appropriate public health services to elderly people could be developed best through joint effort.

Recommendations:

4. That a Task Force on Public Health Services to Elderly People be established, to be composed of two Local Board of Health members, one of whom will act as the Chairperson, the Health Advocate, two representatives from Public Health Nursing, a representative from the Mayor's Committee on Aging and others whom the Task Force may choose to appoint.

5. That the Task Force immediately begin meeting on a regular basis to establish the policy issues which it is going to examine in the context of Public Health in the 1980's and that the Task Force make its initial report to the Local Board of Health at its meeting on Tuesday, June 22, 1982.

APPENDIX A

EXCERPT FROM THE MENTAL HEALTH ACT (R.S.O. 1980, c.262)

Section "9.-(1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack of competence to care for himself,

"and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person,

"the physician may make application in the prescribed form for a psychiatric assessment of the person.

"(2) An application under subsection (1) shall set out clearly that the physician who signs the application personally examined the person who is the subject of the application and made careful inquiry into all of the facts necessary for him to form his opinion as to the nature and quality of the mental disorder of the person.

"(3) A physician who signs an application under subsection (1),

(a) shall set out in the application the facts upon which he formed his opinion as to the nature and quality of the mental disorder;

(b) shall distinguish in the application between the facts observed by him and the facts communicated to him by others; and

(c) shall note in the application the date on which he examined the person who is the subject of the application.

"(4) An application under subsection (1) is not effective unless it is signed by the physician within seven days after he examined the person who is the subject of the examination.

"(5) An application under subsection (1) is sufficient authority for seven days from and including the day on which it is signed by the physician,

(a) to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith; and

(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him in the facility for not more than 120 hours. 1978, c.50, s.3."

Section "10.-(1) Where information upon oath is brought before a justice of the peace that a person within the limits of jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack of competence to care for himself,

"and in addition based upon the information before him the justice of the peace has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person,

"the justice of the peace may issue his order in the prescribed form for the assessment of the person by a physician. 1978, c.50, s.4 (1).

"(2) An order under this section may be directed to all or any constables or other peace officers of the locality within which the justice has jurisdiction and shall name or otherwise describe the person with respect to whom the order has been made. R.S.O. 1970, c.269, s.9 (3).

"(3) An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficient authority for any constable or other peace officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he may be detained for assessment by a physician. 1978, c.50, s.4 (3)."

Section "11. Where a constable or other peace officer observes a person who acts in a manner that in a normal person would be disorderly and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack or competence to care for himself,

"and in addition the constable or other peace officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person,

"and that it would be dangerous to proceed under section 10, the constable or other peace officer may take the person in custody to an appropriate place for assessment by a physician, 1978, c.50, s.5, part."

REFERENCE

1. Sylvia Sherwood and John N. Morris, A Study of the Effects of an Emergency Alarm and Response System for the Aged: A Final Report. NCHSR Grant *HS01788, February, 1980.